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The Equitable Healthcare Survey

OPTIONS FOR CONTROLLING COSTS

A Survey of the American Public and Selected Professionals in the Health Care Field

conducted for
The Equitable Life Assurance Society of the United States

by Louis Harris and Associates, Inc.

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INTRODUCTION

The inflation of health care costs and expenditures is now one of the most important and most seriously debated problems facing the nation. Both public and private spending on health care have grown much faster than the economy, and much faster than anyone anticipated. Total national health care spending has gone from $51 billion in 1967 to more than $300 billion in 1982. In the past year alone, health care costs rose 11.9%, while the consumer price index rose only 3.9%. Health care spending now accounts for over 10% of the gross national product. Policymakers in government and business have been grappling with this problem for the last several years with very little success. The search for new and better policies to contain the high cost of health care is likely to grow even more intense. This survey is designed to help both the government and the private sector in this very difficult task.

There is no shortage of ideas and proposed solutions. These include making changes in the third-party payment system, increasing price competition among health care providers, instituting new controls and regulations on health care services, encouraging health promotion and wellness programs, or educating the public on health care costs and programs.

Although the subject has had great visibility and numerous surveys have shown a high level of general public concern, until now no survey has looked in any detail at the likely reactions of the public, employers, unions, health care providers, and the health insurance industry to the range of options now being debated. The absence of any such survey was a remarkable omission when one recognizes that no new policy will work unless it is acceptable to the American people and changes in significant ways the motives and behavior of health care users and health care providers. To fill that gap, this survey was designed by Louis Harris and Associates and sponsored by The Equitable Life Assurance Society of the United States.

The following groups were surveyed in order to obtain the opinions of a wide range of participants in the health care system:

- A national cross section of 1,501 adults;
- A national sample of 100 physician leaders; that is, physicians who head local, state, and specialty medical societies;
- A sample of 100 hospital administrators, representing the largest hospitals across the nation;
- A sample of 50 senior health insurance executives of the larger insurance companies throughout the nation;
- A sample of 250 corporate benefits officers from companies in the *Fortune* lists of the largest industrial and nonindustrial companies; and
- A national sample of 26 union leaders who are responsible for health care benefits within major trade unions.

The details of the sampling procedure are presented in Appendix A.

Survey Content

Topics explored in the survey are outlined below:

- General attitudes toward the health care system in the U.S. and the system's particular strengths and weaknesses;
- Perception of the reasons for health care cost escalation and possible solutions;
- Attitudes toward a broad range of cost-containment policies and programs in terms of their anticipated effectiveness and acceptability; and
- Attitudes toward various proposed trade-offs between better coverage on the one hand and greater cost to the patient on the other.

In addition, the nationwide sample of the American public was asked a few questions about their utilization of and experience with health care services and health care coverage. The corporate benefits officers and union leaders were also asked a few questions about the health care benefits offered by their organizations and their experience with various cost-containment programs.

A Note on the Tables

Percentages in the tables may add up to more than 100% because of rounding or the acceptance of multiple responses. On the other hand, percentages in the tables may add up to less than 100% because of the exclusion of "not sure" responses. All tables show unweighted percentages for the professional groups and weighted percentages for the public sample, and they indicate the bases on which the responses are percentaged.

In order to limit the length of this report, some of the replies to a very few questions (which either confirm the findings discussed in the report or reveal no intergroup differences) are omitted.

Acknowledgments

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SURVEY HIGHLIGHTS

This summary provides an overview of the highlights of this survey. As with any large-scale study of this type, many important details are not reported in the summary. Interested readers are urged to examine the full report.

1. There is a general consensus that fundamental changes are needed to make the U.S. health care system work better.

The American public, by a three-quarters majority, views the U.S. health care system as needing major changes. This view is shared by large majorities of employers, insurance executives, and unions, and by a marginal majority of hospital administrators. The one exception to this consensus lies with the medical profession: a clear majority of physicians who head medical societies believe that the health care system works pretty well and that only minor changes are needed to improve it.

2. The American public views both the cost of and access to health care services as areas in need of change.

Cost-related and access-related changes head the list of changes in the health care system considered most important by the American public and union leaders. The other professional groups acknowledge the need for cost-related changes, but they also emphasize public education regarding medical programs and costs. The primary change sought by physician leaders is less government interference and regulation.

The public's concern about access centers around care for the elderly. Based on their personal experiences, however, the American people, including the elderly, are largely satisfied with the quality of and access to health care services, and with health insurance benefits.

3. Barriers to medical care.

The 14% of the American public who did not obtain needed medical care in the twelve months preceding this survey include sizable numbers of the uninsured (32%) and the unemployed (28%). The primary barrier to obtaining needed medical care is the cost of this care.

4. There is widespread dissatisfaction with the cost of hospitalization.

While a slight majority of the American public are dissatisfied with the total cost of health care as well as out-of-pocket costs, their criticisms are focused mainly on the cost of hospitalization and the cost of laboratory work and X-rays done outside hospitals and clinics. Smaller majorities of the public also consider the cost of doctors' visits and prescription drugs to be unreasonable.

The view that hospital costs are unreasonable is shared by an overwhelming majority of union leaders, corporate benefits officers, and insurance executives, and by a significant majority of physician leaders. Even among hospital administrators, 40% view hospital costs as unreasonable.

5. There is very little consensus on the main cause of increased spending on health care.

The debate about the main underlying cause of the escalation of health care spending is still unresolved. While slightly more than 40% of the American people view this escalation as due to "the increasing cost of the same services," one-third of this group blame "the use of new and more expensive treatments and equipment." Physician leaders and hospital administrators view the latter reason as the primary cause of escalating expenditures.

"People using more services than they used to" is not acknowledged as a major cause of escalating expenditures by the American public. However, about 30% of physician leaders and hospital administrators recognize it as a primary cause of this escalation.

The views of corporate benefits officers and union leaders tend to parallel those of the public.

6. The health care system as it is today does little to encourage price competition.

Only 16% of the American public have selected a doctor because of lower fees. Comparison shopping for prescription drugs is viewed as easier than shopping for health insurance, doctors, or hospitals. Shopping for laboratory tests and X-rays is viewed as difficult by a sizable majority of the American public.

7. The lack of price competition in the system is acknowledged as a reason for the rise in health care spending.

Large majorities of the American public and of all of the professional groups *except* the physician leaders agree that "the lack of competitive pricing among doctors, hospitals, or nursing homes" contributes to the rise in health care spending.

The opinions of physician leaders contrast sharply with those of all of the other groups, including hospital administrators. While only 37% of the physician leaders blame "lack of price competition" for the increase in health care spending, 68% of hospital administrators do so.

On the other hand, there is general consensus that as long as third-party payers assume all or most of the cost of health care, there is no incentive for patients or providers to cut spending or costs.

8. The American people and most professionals recognize that programs and practices that benefit them are also a source of inflation in health care spending.

Majorities in all groups mention the following as contributing to cost escalation: the increased availability of employer-paid health insurance, hospitalization for minor ailments, the growth of malpractice suits, people staying in hospitals longer than is necessary, the aging of the population, increased availability of government funded programs, and overuse of tests by doctors.

Physician leaders, in general, are least willing to recognize the actions of their own profession as contributing to the rise in health care spending, while hospital administrators have a more balanced view. While majorities of respondents in all groups recognize that "one of the problems in health care is that there is no real competition to keep prices down," only 27% of the physician leaders agree with this view.

9. The American public is ready to accept a broad range of cost-containment proposals.

The conventional wisdom that the American public will resist major changes in the health care system is called into question by the findings of this study.

The American public is remarkably willing to accept a broad range of cost-containment policies, including those that would increase out-of-pocket costs to the public and minimally curtail freedom of choice among health care options.

This willingness to accept proposed changes is based on the belief that the changes will be effective in slowing health care cost inflation. These findings suggest that the public would be willing to accept such changes because of a sense of realism and an understanding that the changes are necessary, rather than because they support them enthusiastically.

The proposals that the public considers most acceptable are: alternatives to the use of hospitals for minor surgery, tests, or the treatment of the chronically ill, increased cost-sharing in the payment of health insurance premiums and increased deductibles, diagnosis-related cost caps on hospital and doctors' fees, requiring second opinions on non-emergency surgery, insurance rate incentives for preventive care, prepaid plans and preferred provider plans, and using low-cost alternatives to physicians and hospital care.

10. Professional groups have varying perspectives on the cost-containment proposals.

Union leaders, corporate benefits officers, and insurance executives generally share the views of the American public, and they are willing to accept almost all of the proposed changes in the health care system.

Hospital administrators are generally willing to accept changes in the health care system in the interest of cost containment, even if the changes mean a reduction in hospital use or a restriction on the fees charged by hospitals.

Physician leaders are the least willing of all groups surveyed to accept — or even to recognize as effective — changes that are likely to adversely affect the financial incentives for their profession.

11. Most corporate executives whose companies have implemented new cost-containment programs believe that the programs are effective.

Corporate executives whose organizations have had experience with various cost-containment measures are more likely to judge them as effective than are those who have had no experience with these measures. This is particularly true for programs that require increased cost-sharing by employees and for those that provide better coverage for lower cost health care options, such as home care for the chronically ill and the use of nurse practitioners, midwives, and physicians' assistants.

12. There is widespread opposition to a proposed tax on employer-paid premiums.

One policy that is rejected by the majority of respondents in most groups as ineffective and unacceptable as a cost-containment measure is the often-discussed individual tax on a portion of the employer-paid health insurance premiums. The physician leaders are the only group in which a clear majority find this proposal to be both effective and acceptable.

13. Shifting costs from Medicare patients to other patients is viewed with disfavor.

The majority of the American public and majorities of all of the professional groups disapprove of the practice of shifting costs from Medicare patients to other patients. This disapproval is voiced as strongly by those who do receive Medicare benefits as those who do not.

14. There is general support for programs that provide health insurance for the unemployed, but it diminishes sharply when viewed as resulting in greater costs for other people.

The American people (including the unemployed) and corporate benefits officers reveal a marginal reluctance to support health care benefits for the unemployed if such benefits result in higher direct or indirect costs to other people. However, sizable minorities (of more than 40%) are in favor of these benefits despite their costs.

Physician leaders, insurance executives, and hospital administrators, on the other hand, favor providing these benefits.

15. Overall, the American public reveals awareness of and concern about health care issues.

The majority of the American public are remarkably aware of and concerned about problems related to health care coverage and health care services. This is reflected in the relatively insignificant numbers of respondents who give "not sure" or "no opinion" responses to the questions asked in this survey.

CHAPTER 1:
GENERAL ATTITUDES TOWARD THE HEALTH CARE SYSTEM

Overall View of the Health Care System

A majority of the American public (75%) view the health care system in this country as needing major changes (Table 1-1).[1] In choosing the one statement among three that best expresses their view of the health care system, 50% say "there are some good things in our health care system, but fundamental changes are needed to make it work better." This view is shared by a majority of health insurance executives (80%), corporate benefits officers (79%), union leaders (69%), and hospital administrators (56%). While 25% of Americans view the health care system as having "so much wrong with it that we need to completely rebuild it," small minorities of the professional groups (2% to 12%) hold this view.

The views of physician leaders are remarkably different from those of the other groups: 32% say the health care system needs "fundamental changes to make it work better"; none of the physician leaders see a need to "completely rebuild it"; and the majority (68%) feel that "on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better." This latter view is held by 21% of the American public, 41% of hospital administrators, 19% of union leaders, 16% of insurance executives, and 12% of corporate benefits officers (Table 1-1).

Older Americans (30% or more of those aged 40 and over), the retired (34%), the unemployed (30%), the uninsured (38%), those in fair or poor health (35%), and those with Medicare coverage (30%) are most likely to see a "need to completely rebuild" the health care system (Tables 1-2, 1-3, and 1-4).

Observation:
Health care providers seem to have the most favorable view of the American health care system. Physician leaders are most likely to be content with the status quo, while hospital administrators are likely to be somewhat more critical of the system. Clearly, these views are colored by the extent to which the present health care system serves the interests of the groups interviewed.

1 Similar findings were obtained in a survey of the American public conducted for the Robert Wood Johnson Foundation on "Access to Health Care Services in the United States" (Summer 1982).

Table 1-1

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC AND PROFESSIONALS COMPARED

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	68	41	16	12	19
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	32	56	80	79	69
The American health care system has so much wrong with it that we need to completely rebuild it	25	-	2	4	8	12
Not sure	4	-	1	-	1	-

Table 1-2

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC BY AGE

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

		Age				
	Total	18-29 Years	30-39 Years	40-49 Years	50-64 Years	65 and Over
No. of Respondents	1501	400	358	208	305	225
	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	20	21	22	20	22
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	64	53	43	45	33
The American health care system has so much wrong with it that we need to completely rebuild it	25	14	24	31	33	30
Not sure	4	2	2	3	1	15

Table 1-3

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC BY OCCUPATIONAL STATUS

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

		Occupational Status				
	Total	Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	20	22	21	26	22
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	54	55	34	37	62
The American health care system has so much wrong with it that we need to completely rebuild it	25	23	22	34	30	14
Not sure	4	3	1	10	6	1

Table 1-4

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	**1501**	**1253**	**247**	**1016**	**300**	**94**	**687**	**75**
	%	%	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	21	20	22	23	25	21	13
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	53	38	52	37	39	51	42
The American health care system has so much wrong with it that we need to completely rebuild it	25	23	35	23	30	26	24	38
Not sure	4	3	8	3	10	10	4	7

Suggested Changes for the Health Care System

The major areas of concern about the American health care system are cost and access. Most of the changes in the system that are widely desired relate to cost or access or both.

Table 1-5 indicates the changes the groups suggested spontaneously when they were asked for the *one* change they would make in the U.S. health care system. Cost-related changes are suggested by 31% of union leaders, 28% of corporate benefits officers, 24% of insurance executives, 23% of the American public, 19% of hospital administrators, and only 14% of the physician leaders. Access-related (and indirectly, cost-related) changes are of most interest to the American public (24%) and union leaders (23%).

The length of the list of suggested changes presented in Table 1-5 indicates that the American public and the professional groups have varied and wide-ranging concerns about the health care system. Only the changes suggested most frequently within each group are highlighted in the text that follows.

- **American Public**
  - "Control or limit costs" (12%);
  - "More or better care for the elderly, more inclusive Medicare" (11%);
  - "Socialized medicine or national health service" (8%);
  - "Lower hospital costs" (5%);
  - "Assure availability of equal quality care for all" (5%); and
  - "For those who can't afford it, cut costs or provide financial support" (5%).

Clearly, the professional groups interviewed have varying priorities for change. The suggestions made most frequently within each professional group are:

- **Physician Leaders**
  - "Less government interference/regulation" (15%);
  - "Public education regarding medical programs and costs" (13%);
  - "People should pay more of the cost of health care" (8%); and
  - "Control/limit costs" (8%).
- **Hospital Administrators**
  - "Control/limit costs" (13%);
  - "Need better insurance coverage, or reevaluate coverage" (8%); and
  - "Change fee for service system to capitation/prospective payment" (8%).
- **Insurance Executives**
  - "Control/limit costs" (16%);
  - "Public education regarding medical programs and costs" (10%);
  - "Change fee for service system to capitation/prospective payment" (8%); and
  - "Need better insurance coverage/reevaluate coverage" (8%).
- **Corporate Benefits Officers**
  - "Control/limit costs" (18%);
  - "Public education regarding medical programs and costs" (12%).
- **Union Leaders**
  - "Socialized medicine, national health service" (31%);
  - "Control/limit costs" (15%);
  - "Assure availability of equal quality care for all" (12%);
  - "Lower hospital costs" (8%); and
  - "More or better care for the elderly, more inclusive Medicare" (8%).

The data on suggested changes are fairly uniform across the various subgroups within the American public and therefore are not detailed here.

The suggestions for change in the health care system mentioned by the American public have not changed substantially since 1980, as is evident in the data presented in Table 1-6. However, the priorities have shifted marginally, with concern about access to health care having increased, and concern about cost having declined. The increased public concern about access is focused on the elderly and Medicare.

Observation:
Data reported elsewhere in this report (Table 1-7) suggest that the interest in the cost issue is based on a personal dissatisfaction with both the total and the out-of-pocket costs of health care. On the other hand, additional data (Tables 1-7 and 1-15) reveal that access to health care services is not a problem for the majority of the American public. Thus, it appears that the interest in access-related changes may reflect either a concern for that small segment of the population who do have access problems, or it may be based on a mistaken perception of the extent of the access problem.

The distinction between cost and access is important wherever policies designed to reduce or control costs could also diminish ease of access to health care services.

Table 1-5

SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM: THE PUBLIC AND PROFESSIONALS COMPARED

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Cost-Related Changes (Total)	23	14	19	24	28	31
Control or limit costs	12	8	13	16	18	15
Lower hospital costs	5	2	-	2	6	8
Reduce doctors' charges	4	2	3	6	3	4
Government should cover health care/insurance costs	2	2	3	-	*	4
Access-Related Changes (Total)	24	13	17	8	8	23
More/better care for the elderly, more inclusive Medicare	11	-	-	-	*	8
Assure availability of equal quality care for all	5	4	2	-	1	12
For those who can't afford it, cut costs/provide financial support	5	3	7	-	2	-
Need better insurance coverage, reevaluate coverage	3	6	8	8	4	4
Other Specific Reasons						
Socialized Medicine, national health service	8	-	5	2	1	31
Less impersonal doctor/ patient relationship	3	6	3	-	*	-
Preventive medicine should be implemented/ augmented	2	3	2	4	3	-
Eliminate waste/fraud/ graft/pilfering/handouts	2	-	4	2	1	4
Better hospitals — care, attitudes, integrity	2	1	-	2	1	-

Continued

Table 1-5 (Continued)

SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM: THE PUBLIC AND PROFESSIONALS COMPARED

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Other Specific Reasons (Continued)						
Public education regarding medical programs and costs	2	13	4	10	12	4
More research, find cures	2	1	2	-	*	-
More doctors/students in medical schools	2	1	2	-	1	-
People should pay more of the cost of health care	1	8	6	2	6	-
Eliminate unnecessary use of facilities/Medicaid/ Medicare	1	1	-	6	6	-
Better doctors: responsibility, proficiency, attitude	1	-	2	4	1	-
Less government interference/ regulation	1	15	6	2	2	-
Investigate/regulate insurance companies	1	-	-	-	1	4
Change fee for service system to capitation/ prospective payment	1	2	8	8	4	-
More investigation of third-party reimbursement	*	6	3	6	2	-
Increase competition between doctors	*	-	1	2	3	-
Increase formation/ use of HMO's	*	1	3	-	2	-
Utilization/peer review	*	1	-	4	1	-
All Other Reasons Mentioned (Total)	6	3	9	14	10	4
Don't know, not sure	18	5	2	2	9	-

*Less than 0.5%.

Table 1-6
SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM: TRENDS

Base: Public cross section

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

	Total	
	May/June 1983	October 1980[1]
No. of Respondents	1501	1538
	%	%
Cost-Related Changes (Total)	23	30
Control/limit costs	12	10
Lower hospital costs	5	4
Reduce doctors' charges	4	6
Government should cover health care/insurance costs	2	4
Make it less expensive (nonspecific)	-	6
Access-Related Changes (Total)	24	17
More/better care for the elderly, more inclusive Medicare	11	7
Assure availability of equal quality care for all	5	4
For those who can't afford it, cut costs/provide financial support	5	5
Need better insurance coverage, reevaluate coverage	3	1
Other Suggested Changes[2]		
Socialized Medicine, national health service	8	7
Less impersonal doctor/patient relationship	3	4
Preventive medicine should be implemented/augmented	2	1
Eliminate waste/fraud/graft pilfering/handouts	2	2
Better hospitals — care, attitudes, integrity	2	2*
Public education regarding medical programs and costs	2	-
More research, find cures	2	1
More doctors/students in medical schools	2	3

1 Source: *1980 Lou Harris Perspective: Healthcare*

2 Only specific suggestions mentioned by 2% or more of the sample are reported in this table.

Satisfaction and Dissatisfaction With Health Care

High levels of satisfaction with the quality and availability of health care and with health insurance benefits contrast sharply with widespread dissatisfaction with both the total and the out-of-pocket costs of health care.

Respondents in all groups were asked to indicate how satisfied or dissatisfied they are with specific aspects of health care. These data are presented in Table 1-7.

Interesting differences are evident in the extent of satisfaction with specific aspects of health care expressed by the various groups interviewed. While 88% or more of the respondents from the professional groups are very or somewhat satisfied with the quality of health care, generally, only 77% of the American public are satisfied.

Satisfaction with the availability of health care is lowest among union leaders (62%), followed by that of the general public (75%); more than 85% of the other professional groups express satisfaction with the availability of health care. Satisfaction with health insurance benefits is highest among insurance executives and corporate benefits officers (96% each), followed by that among physician leaders (89%), union leaders (88%), and hospital administrators (79%); it is lowest among the American public (70%).

Although the various groups are collectively least satisfied with the cost of health care (both out-of-pocket cost and total cost), hospital administrators, insurance executives, corporate benefits officers, and union leaders are less satisfied with the total cost than with the out-of-pocket costs.

Over 50% of the American public express dissatisfaction with both types of cost, with the greatest dissatisfaction, not surprisingly, being expressed by those who have no insurance coverage (Table 1-8). This latter group is generally less satisfied with the other aspects of health care as well than are those who have health care coverage. Those in fair or poor health also express greater dissatisfaction with all aspects of health care than is expressed by those in good or excellent health. The former group is particularly dissatisfied with out-of-pocket costs of health care.

Table 1-9 presents the trends in the satisfaction with the various aspects of health care expressed by the American public. While on the one hand the American public has progressively grown less satisfied with the quality of health care generally, on the other hand, they are more satisfied with the total cost of health care (i.e., the cost paid by both the patients and their insurance) than they were in 1978 or 1980.

Table 1-7

SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE: THE PUBLIC AND PROFESSIONALS COMPARED

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**1501**	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%	%
The availability of health care						
Very satisfied	39	60	49	70	68	27
Somewhat satisfied	36	33	37	28	30	35
Somewhat dissatisfied	16	7	7	2	3	23
Very dissatisfied	7	-	3	-	-	12
The quality of health care generally						
Very satisfied	30	84	58	54	41	23
Somewhat satisfied	47	16	34	42	49	65
Somewhat dissatisfied	14	-	5	4	8	8
Very dissatisfied	6	-	-	-	1	4
Your health insurance benefits						
Very satisfied	37	55	52	74	66	65
Somewhat satisfied	33	34	27	22	30	23
Somewhat dissatisfied	15	7	13	4	2	8
Very dissatisfied	10	4	6	-	1	4
The total cost of health care, including what both you and your insurance pay						
Very satisfied	18	27	17	4	17	19
Somewhat satisfied	28	34	36	20	15	27
Somewhat dissatisfied	25	28	31	40	31	23
Very dissatisfied	25	11	15	36	36	27
The out-of-pocket cost of health care						
Very satisfied	16	26	30	42	39	38
Somewhat satisfied	26	41	37	28	29	31
Somewhat dissatisfied	26	25	22	26	18	19
Very dissatisfied	28	5	11	2	10	12

Table 1-8

SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE: THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
The availability of health care								
Very satisfied	39	40	34	41	39	39	38	23
Somewhat satisfied	36	36	34	36	33	40	36	43
Somewhat dissatisfied	16	15	19	15	16	11	16	18
Very dissatisfied	7	6	9	6	7	6	7	13
Your health insurance benefits								
Very satisfied	37	39	26	41	35	40	35	x
Somewhat satisfied	33	33	32	35	30	28	36	x
Somewhat dissatisfied	15	14	20	14	17	19	17	x
Very dissatisfied	10	9	14	7	11	6	9	x
The quality of health care generally								
Very satisfied	30	31	26	31	32	21	29	21
Somewhat satisfied	47	47	47	48	44	52	50	47
Somewhat dissatisfied	13	14	14	13	11	19	13	20
Very dissatisfied	6	6	10	6	8	7	6	11
The total cost of health care, including what both you and your insurance pay								
Very satisfied	18	19	14	21	19	21	17	4
Somewhat satisfied	28	28	28	30	29	31	30	12
Somewhat dissatisfied	25	26	24	24	22	22	26	32
Very dissatisfied	25	24	28	22	25	21	24	42
The out-of-pocket cost of health care								
Very satisfied	16	17	10	18	13	14	13	8
Somewhat satisfied	26	26	25	27	27	27	26	12
Somewhat dissatisfied	26	27	22	26	23	21	28	15
Very dissatisfied	28	27	36	25	32	33	28	63

x = This item was not applicable to this group.

Table 1-9

SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE: TRENDS

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Total		
	May/June 1983	October 1980[1]	December 1978[2]
No. of Respondents	**1501**	**1538**	**1539**
	%	%	%
The quality of health care generally			
Very/somewhat satisfied	77	82	87
Very/somewhat dissatisfied	20	15	13
The availability of health care			
Very/somewhat satisfied	75	81	79
Very/somewhat dissatisfied	23	18	20
Your health insurance benefits			
Very/somewhat satisfied	70	69	x
Very/somewhat dissatisfied	25	23	x
The total cost of health care, including what both you and your insurance pay[3]			
Very/somewhat satisfied	46	28	31
Very/somewhat dissatisfied	50	69	68
The out-of-pocket cost of health care			
Very/somewhat satisfied	42	x	x
Very/somewhat dissatisfied	54	x	x

1 Source: *1980 Lou Harris Perspective: Healthcare*

2 Source: *1978 Lou Harris Perspective: Healthcare*

3 In 1980, this item was "The cost of health care."

x = Not asked.

Satisfaction and Dissatisfaction With the Cost of Health Care Services

There is widespread dissatisfaction with the cost of hospitalization and a plurality of opinion on the cost of other services. Health care providers are more likely to consider the cost of various services to be reasonable, while union leaders display the greatest dissatisfaction with these costs.

Respondents in all groups were asked how reasonable they considered the cost of various health care services and health insurance (Table 1-10).

Relative to the other items, the American public is most satisfied with the cost of health insurance, which only a scant majority (51%) consider very or somewhat reasonable. The cost of hospitalization is considered unreasonable by a clear majority, while marginal majorities consider the remaining services unreasonable.

The differences in the opinions of the professional groups regarding the cost of the various services are as follows: relative to the other groups the physician leaders are the group most satisfied with all services except hospitalization; union leaders generally have the most critical views on cost of specific services, particularly the cost of hospitalization and doctors' visits; corporate benefits officers are second only to union leaders in their criticism of hospital and physician costs, but they generally hold moderate views on the cost of other services; hospital administrators are most likely to consider the cost of hospitalization and health insurance reasonable; and insurance executives are primarily critical of hospital costs.

As would be expected, Table 1-11 reveals that while about half the American public considers the cost of health insurance reasonable, only 25% of those without any health care coverage think so. While the difference of opinion is not as great for the other services, the uninsured are least likely to consider any of these services as being of reasonable cost. Those in fair or poor health are more critical of all costs than are those in good or excellent health.

Since 1978, public views on the "unreasonableness" of the cost of hospitalization have become more widespread; negative views towards the cost of doctors' visits and prescription drugs have risen marginally (Table 1-12).

Table 1-10

ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES: THE PUBLIC AND PROFESSIONALS COMPARED

Q. Do you think the cost (to you and your household) of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Health insurance						
Very reasonable	20	17	17	16	12	8
Somewhat reasonable	31	55	49	42	35	27
Somewhat unreasonable	24	25	25	40	34	27
Very unreasonable	20	2	8	2	17	35
Prescription drugs						
Very reasonable	14	15	12	6	2	4
Somewhat reasonable	30	56	39	40	48	23
Somewhat unreasonable	28	21	36	34	36	31
Very unreasonable	26	6	10	20	12	38
Doctors' visits						
Very reasonable	13	35	10	4	2	-
Somewhat reasonable	32	50	47	42	33	15
Somewhat unreasonable	29	12	34	46	47	42
Very unreasonable	22	-	7	8	17	42
Hospitalization						
Very reasonable	11	8	17	2	4	-
Somewhat reasonable	22	27	43	16	13	4
Somewhat unreasonable	27	51	25	46	48	54
Very unreasonable	36	12	15	34	35	42
Laboratory tests and X-rays outside hospitals and clinics						
Very reasonable	9	26	8	6	5	4
Somewhat reasonable	24	48	45	36	39	31
Somewhat unreasonable	29	22	27	46	36	31
Very unreasonable	27	3	9	8	17	31

Table 1-11

ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES: THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE

Base: Public cross section

Q. Do you think the cost to you and your household of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Health insurance								
Very reasonable	20	22	13	25	20	18	16	10
Somewhat reasonable	31	31	28	32	29	36	36	15
Somewhat unreasonable	24	23	28	23	22	25	25	17
Very unreasonable	20	19	26	16	23	17	20	43
Prescription drugs								
Very reasonable	14	14	11	16	12	12	12	6
Somewhat reasonable	30	31	22	30	21	27	29	27
Somewhat unreasonable	28	28	25	27	29	35	29	33
Very unreasonable	26	23	38	24	36	22	26	31
Doctors' visits								
Very reasonable	13	14	11	14	14	13	14	6
Somewhat reasonable	32	33	30	34	25	40	32	19
Somewhat unreasonable	29	29	26	28	29	25	30	33
Very unreasonable	22	20	29	21	26	17	21	35
Hospitalization								
Very reasonable	11	11	11	13	10	15	10	5
Somewhat reasonable	22	24	14	23	20	29	24	20
Somewhat unreasonable	27	27	27	26	23	20	29	19
Very unreasonable	36	34	45	33	44	35	35	54
Laboratory tests and X-rays outside hospitals and clinics								
Very reasonable	9	9	9	10	8	14	9	7
Somewhat reasonable	24	24	19	25	21	21	23	20
Somewhat unreasonable	29	30	26	30	26	24	29	30
Very unreasonable	27	26	32	26	29	28	27	36

Table 1-12

ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES: TRENDS

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Total		
	May/June 1983	October 1980[1]	December 1978[2]
No. of Respondents	1501	1538	1539
	%	%	%
Health Insurance			
Very reasonable	20	x	x
Somewhat reasonable	31	x	x
Somewhat unreasonable	24	x	x
Very unreasonable	20	x	x
Doctors' visits			
Very reasonable	13	11	10
Somewhat reasonable	32	35	39
Somewhat unreasonable	29	32	28
Very unreasonable	22	19	18
Prescription drugs			
Very reasonable	14	8	8
Somewhat reasonable	30	32	34
Somewhat unreasonable	28	33	30
Very unreasonable	26	20	20
Hospitalization			
Very reasonable	11	11	12
Somewhat reasonable	22	26	29
Somewhat unreasonable	27	28	25
Very unreasonable	36	26	25
Laboratory tests and X-rays outside hospitals and clinics			
Very reasonable	9	x	x
Somewhat reasonable	24	x	x
Somewhat unreasonable	29	x	x
Very unreasonable	27	x	x

1 Source: *1980 Lou Harris Perspective: Healthcare*

2 Source: *1978 Lou Harris Perspective: Healthcare*

x = Not asked

Comparison Shopping for Health Care Services

Price sensitivity is not a factor in the selection of a physician. The American public finds it easier to shop around for health care coverage and prescription drugs than for providers.

The data on the ease of shopping for health care services as assessed by the American public are presented in Table 1-13. While about 50% of the public find it very or somewhat easy for consumers to shop around for health insurance, hospitals, and doctors, 67% find it easy for consumers to shop around for prescription drugs, and only 31% find it easy to shop around for laboratory tests and X-rays. These findings are not surprising since physicians are more likely to direct their patients to certain facilities for laboratory work than they are to direct their patients to specific pharmacies or drugstores.

While 49% of the American public consider it easy to shop around for physicians, only 16% have actually selected a doctor because of lower fees (Table 1-14). Again, as would be expected, the uninsured are more likely to have done so than are those with some form of health care coverage.

Table 1-13

EASE OF SHOPPING AROUND FOR HEALTH CARE SERVICES

Base: Public cross section

Q. I will read a list of five products and services. Please say, for each one, *how easy or difficult* it is for consumers to check prices and value, in order to *shop around* for the best buy. Is it very easy, somewhat easy, somewhat difficult, or very difficult for consumers to shop around for (READ EACH ITEM)?

	Total
No. of Respondents	1501
	%
Prescription drugs	
Very easy	35
Somewhat easy	32
Somewhat difficult	18
Very difficult	12
Health insurance	
Very easy	24
Somewhat easy	32
Somewhat difficult	24
Very difficult	13
Hospitals	
Very easy	23
Somewhat easy	26
Somewhat difficult	25
Very difficult	21
Doctors	
Very easy	22
Somewhat easy	27
Somewhat difficult	29
Very difficult	19
Laboratory tests and X-rays outside hospitals and clinics	
Very easy	13
Somewhat easy	18
Somewhat difficult	29
Very difficult	31

Table 1-14

SELECTION OF DOCTOR BECAUSE OF LOWER FEES

Base: Public cross section

Q. Other things being equal, have you ever selected a particular doctor because his or her fees were lower than another's, or haven't you?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Yes, have selected	16	17	15	16	8	17	15	36
No, have not selected	83	82	84	83	91	80	84	64

Barriers to Obtaining Medical Care

Cost is the primary reason that a small minority of the American public did not obtain needed medical care.

Overall, 14% of the American public indicate that there was a time in the twelve months preceding the interviews when someone in the family failed to receive needed medical help (Table 1-15). The percentages that fall into this category are particularly high among the uninsured (32%), the unemployed (28%), and those that are employed part-time (21%).

The reasons cited most frequently for not obtaining needed medical help is "it cost too much." Forty-five percent of the respondents give this reason, while only 12% and 10% give the next most frequently cited reasons, "not covered by insurance" and "could not get an appointment," respectively (Table 1-16).

Table 1-15
FAMILIES WHO DID NOT GET NEEDED MEDICAL HELP IN THE PAST TWELVE MONTHS

Base: Public cross section

Q. Was there any time in the last year — since (DATE ONE YEAR AGO) 1982 — that you felt you or a member of your family living with you needed medical help but did not get it for some reason?

	No. of Respondents		Yes, There Was a Time	No, There Wasn't a Time
Total	**1501**		**14**	**86**
Health Status				
Excellent/Good	1253	%	13	86
Fair/Poor	247	%	18	82
Type of Health Care Coverage				
Through work or union	1016	%	14	86
Medicare	300	%	8	92
Medicaid	94	%	18	82
Other coverage	687	%	12	87
None	75	%	32	66
Employment Status				
Employed full-time	800	%	14	86
Employed part-time	159	%	21	78
Retired	272	%	6	93
Unemployed	88	%	28	71
Student/housewife	172	%	12	87

Table 1-16

MAIN REASON FOR NOT GETTING NEEDED MEDICAL HELP

Base: Those in the public cross section who did not obtain needed medical help in the past twelve months

Q. What was the *main* reason that your family did not get the medical help needed in this situation?

	Total
No. of Respondents	**219**
	%
It cost too much	45
Not covered by insurance	12
Could not get an appointment	10
There was no easy way to get to the doctor's office or clinic	5
Too nervous or afraid	4
Would have had to wait too long in the doctor's office or clinic	3
Did not know a good doctor or clinic to go to	3
Could not get off work	2
Other reasons[1]	13

1 Each reason was mentioned by one or two respondents

CHAPTER 2:
PERCEIVED REASONS FOR THE INCREASE IN HEALTH CARE EXPENDITURES AND COSTS

Reasons for Increased Health Spending

Health care consumers — the American public, corporate benefits officers, and union leaders — see an increase in the unit cost of health care services as the primary reason for escalating health care costs, while care and coverage providers (physician leaders, hospital administrators, and insurance executives) tend to blame the use of expensive treatments and equipment more than other factors.

When asked to identify which of three general reasons was most responsible for the increase in spending on health care services over the past several years, 44% of the American public cite "the increasing cost of the same services," and 34% cite "the use of new and more expensive treatments and equipment." Only 17% feel that "people using more health care services than they used to" is the main reason for escalating expenditures (Table 2-1).

The views of corporate benefits officers and union leaders generally parallel those of the American public, while those of physician leaders, hospital administrators, and insurance executives are quite different. These latter three groups cite "the use of new and more expensive treatments and equipment" more often than they do the other two reasons as the main reason for escalating expenditures. While insurance executives cite the other two reasons with about equal frequency, physician leaders and hospital administrators cite "people using more health care services than they used to" by more than a 3-to-2 majority over "the increasing cost of the same services."

Table 2-2 indicates the extent to which each of ten specific practices is believed to have contributed to the rise in health care spending. The greatest consensus of opinion is observed in the view expressed by more than 90% of respondents in each group that the "increasing use of expensive new equipment and technology" has contributed very much or somewhat to the increased health care spending in this country.

There is also considerable consensus within each group (77% or more) that "the increased availability of government-funded programs such as Medicare and Medicaid" and that "the fact that the population as a whole is getting older and older people require more medical services" contribute to the rise in health care spending.

While 80% or more within each of the other samples agree that "doctors ordering more laboratory tests than are necessary" is a contributing factor, only 69% of the physician leaders do so. Similarly, the physician leaders are less likely (37%) than are the other groups (68% to 90%) to cite "the lack of competitive pricing among doctors, hospitals, or nursing homes" as a contributing factor.

Whereas well over half of the respondents in other groups cite "fraud and abuse by some nursing homes, doctors, and hospitals" as contributing factors, less than half the physician leaders (24%) and hospital administrators (42%) do so.

Over 75% of respondents in each group agree that "the growth of expensive malpractice suits which require doctors to pay for malpractice insurance" is a contributing factor, with the physician leaders most likely (91%) to say so.

"Patients being hospitalized for minor ailments that can be treated without hospitalization" and "people staying in hospitals longer than necessary" are cited as reasons for increased spending by more than half of the respondents in all groups. The physician leaders and hospital administrators cite these as contributing factors by smaller margins than do the other groups.

"The increased availability of health insurance provided by employers" is most likely to be viewed as a contributing factor by those who provide it — insurance executives (94%) and corporate benefits officers (93%) — and least likely to be viewed as a contributing factor by those who benefit from it — union leaders (65%) and the public (70%). However, it should be noted that clear majorities in these two groups recognize it as a reason for the rise in health care spending.

Observation
In general, it appears that the physician leaders are least willing to recognize their own actions as being responsible for the rise in health care spending, while the American public recognizes that programs and practices that benefit them are also a source of inflation in health care spending.

Table 2-1

MAIN REASON FOR INCREASED SPENDING ON HEALTH CARE SERVICES

The amount of money spent on health care services has been growing rapidly over the last fifteen years. Total national health care spending has gone from 51 billion dollars in 1967 to over 300 billion dollars last year.

The increased amount of money spent on health care services is partly a result of *people using more health care services than they used to*, partly a result of *the use of new and more expensive treatments and equipment*, and partly a result of the *increasing cost of the same services*.

Q. Which one of these three do you think is the main reason for the increased spending on health care services? I will read the three reasons again if you like.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**1501**	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%	%
The increasing cost of the same services	44	19	16	26	44	54
The use of new and more expensive treatments and equipment	34	46	49	40	38	27
People using more health care services than they used to	17	31	29	24	15	12
Not sure	4	3	4	10	2	4

Table 2-2

SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING

Q. I will read you some reasons that are given for the rise in health care spending over the last few years. For each reason, please tell me if you think it has contributed very much, somewhat, not very much, or not at all to the increased health care spending in this country.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
The increasing use of expensive new equipment and technology						
Very much	50	47	45	46	48	42
Somewhat	40	47	54	52	50	54
Not very much	6	5	1	2	2	4
Not at all	1	-	-	-	-	-
Doctors ordering more laboratory tests than are necessary						
Very much	46	11	26	50	40	46
Somewhat	34	58	54	36	52	46
Not very much	13	28	18	12	8	8
Not at all	4	2	2	2	*	-
The growth of expensive malpractice suits which require doctors to pay for expensive malpractice insurance						
Very much	44	40	20	28	22	23
Somewhat	36	51	64	48	57	54
Not very much	12	9	15	24	20	19
Not at all	4	-	1	-	1	4
The lack of competitive pricing among doctors, hospitals, or nursing homes						
Very much	44	4	29	38	56	58
Somewhat	33	33	39	42	34	27
Not very much	14	42	23	18	8	12
Not at all	5	17	8	2	1	-
Patients being hospitalized for minor ailments that can be treated without hospitalization						
Very much	42	15	25	44	47	27
Somewhat	35	46	39	44	40	42
Not very much	16	32	31	10	11	19
Not at all	4	7	5	2	1	4

Continued

Table 2-2 (Continued)

SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**1501**	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%	%
The increased availability of government-funded programs such as Medicare and Medicaid						
Very much	37	56	50	60	44	35
Somewhat	42	36	36	36	44	50
Not very much	13	8	10	4	11	15
Not at all	5	-	2	-	1	-
Fraud and abuse by some nursing homes, doctors, and hospitals						
Very much	36	-	6	8	11	23
Somewhat	37	24	36	52	48	54
Not very much	17	67	51	40	38	15
Not at all	3	8	6	-	1	-
The fact that the population as a whole is getting older, and older people require more medical services						
Very much	32	65	52	48	21	38
Somewhat	45	34	39	40	60	54
Not very much	16	1	7	12	18	8
Not at all	5	-	2	-	*	-
People staying in hospitals longer than necessary						
Very much	32	6	8	24	28	12
Somewhat	34	47	46	54	52	69
Not very much	24	43	42	22	20	15
Not at all	7	4	4	-	1	4
The increased availability of health insurance provided by employers						
Very much	26	38	34	46	55	19
Somewhat	44	50	49	48	38	46
Not very much	19	11	14	4	6	31
Not at all	6	1	3	2	*	-

*Less than 0.5%.

Underlying Causes of the Increase in Health Care Spending

It is widely recognized that as long as third-party payers assume all (or most) of the cost of health care, providers and patients have no incentive to pare down services or usage.

Four statements describing possible underlying causes of the increase in health care spending were presented to the respondents — two statements reflected on patient behavior and two reflected on provider behavior.

In all of the groups except union leaders, 78% or more of the respondents agreed with the first two statements — "if most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is" and "people would use fewer health care services if they personally had to pay a greater share of the cost" (Table 2-3).

Agreement with the statement, "one of the problems with health care is that there is no real competition to keep prices down," is expressed by more than 75% of the American public, insurance executives, union leaders and corporate benefits officers, by 55% of the hospital administrators, but by only 27% of the physician leaders.

While more than 60% of all the other groups agree with the statement "if doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost," only 53% of the physician leaders agree with it.

Table 2-3

UNDERLYING CAUSES OF THE INCREASE IN HEALTH CARE SPENDING

Q. Now, I will read you some statements about some causes for the increase in health care spending and some possible solutions. Please tell me, for each one, if you agree with it or disagree with it.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**1501**	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%	%
If most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is						
Agree	84	92	85	90	93	81
Disagree	15	8	15	10	6	15
People would use fewer health care services if they personally had to pay a greater share of the cost						
Agree	78	96	92	94	96	69
Disagree	20	3	6	6	4	27
One of the problems with health care is that there is no real competition to keep prices down						
Agree	76	27	55	80	89	81
Disagree	21	73	42	20	10	19
If doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost						
Agree	74	53	63	78	86	69
Disagree	24	46	36	22	13	27

Reasons for the Increased Concentration of Health Care Spending

It is generally recognized that the majority of health care expenditures are incurred by a fairly small minority of the population.

The professional groups were asked to estimate what percentage of all health care costs were incurred by the highest-spending 10% of the population. A breakdown of these estimates is presented in Table 2-4. The median estimates range from 36% by union leaders to 59% by corporate benefits officers.

Observation:
Although at the writing of this report hard evidence is not available on the correct answer to the above question, experts estimate that this percentage is in excess of 60%.[1]

The reasons considered to contribute most to the increased concentration are listed in Table 2-5. The two reasons cited most frequently by physician leaders and hospital administrators are: first, "the aging of the population," and second, "the use of expensive procedures to save or prolong life." Union leaders cite the above two reasons equally often (23% each), and cite "overuse and abuse of health care services by a few people" a little less frequently (19%). Insurance executives cite "overuse and abuse of health care services by a few people" substantially more frequently (28%) than they cite any other reason (18% or less).

While 22% of corporate benefits officers view "use of expensive procedures" as contributing most to the increased concentration of health care spending, they do not appear to agree on any other single reason.

1 A study of the Federal Employee Benefit Program conducted by the Congressional Budget Office in 1978 reports that 10% of the families covered accounted for 67% of the total expenditures. The Health Care Financing Administration reports that in 1978, 8.8% of the elderly enrolled in Medicare accounted for 70.3% of the expenditures.

Table 2-4

ESTIMATES OF THE PERCENTAGE OF HEALTH CARE COSTS INCURRED BY THE HIGHEST-SPENDING 10% OF THE POPULATION

Base: Professional groups only

Q. It is clear that some people incur more health care costs than others. What percentage of all health care costs do you think is incurred by the 10% of the population who are the biggest consumers and who incur the highest costs?

	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	100	100	50	250	26
	%	%	%	%	%
Less than 30%	11	8	4	8	19
30% to 39%	15	14	22	13	15
40% to 49%	21	23	18	8	8
50% to 59%	17	13	8	12	-
60% to 75%	20	21	30	23	12
More than 75%	6	7	14	17	4
Not sure	9	14	4	18	39
Median	49%	49%	55%	59%	36%

Table 2-5

REASONS FOR THE INCREASED CONCENTRATION OF HEALTH CARE SPENDING

Base: Professional groups only

Q. The evidence is that the concentration of health care costs is growing. In other words, the 10% who incur the highest costs are consuming a higher and higher proportion of all costs. Which one of the following do you think contributes most to the increased concentration of health care spending?

	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%
Aging of the population	31	30	18	13	23
Use of expensive procedures to save or prolong life	23	22	18	22	23
Overuse and abuse of health care services by a few people	14	6	28	17	19
New medical technology	10	14	12	16	12
Unhealthy lifestyles	10	14	16	14	4
More insurance coverage	7	10	2	16	8
None of these (vol.)	-	1	4	*	8
Not sure	5	3	2	1	4

*Less than 0.5%

CHAPTER 3:
REACTIONS TO PROPOSED COST-CONTAINMENT CHANGES IN HEALTH CARE SERVICES AND COVERAGE

Introduction

The American public rated nineteen proposed cost-containment policies and programs on how effective and how acceptable they felt each would be from their personal perspective. The professional groups similarly rated the effectiveness of each of these nineteen programs and proposals as well as five additional ones. They also rated the twenty-four policies and programs on their acceptability. Tables 3-1 and 3-2 present these data.

Each proposal will be discussed in terms of its effectiveness and acceptability, as it was judged by each sample interviewed. For the purposes of this discussion, the two positive responses, "very effective" and "somewhat effective" will be collapsed into one, as will the responses "very acceptable" and "somewhat acceptable." The reader is encouraged to examine the detailed breakdown of responses presented in the tables.

General Findings

The conventional wisdom that the American public would resist major changes in the health care field appears to be unfounded. The findings reported in this chapter suggest that in making these changes, employers and the government would be likely to meet much less resistance from the public than generally is believed.

The major finding is the remarkable acceptance by the public of a broad range of policies, including those that would increase out-of-pocket costs and minimally curtail freedom of choice among health care options.

Other general findings of note are the willingness of hospital administrators to accept policies that would result in a reduction in hospital use and income, and the contrasting unwillingness of physician leaders to accept changes, particularly those likely to adversely affect the current financial incentives for the profession.

Detailed Findings

For the purpose of discussing the detailed findings, the proposed cost-containment policies and programs are grouped together on the basis of common underlying themes.

- **Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more out-of-pocket cost to the American public**

The American public is surprisingly willing to recognize the effectiveness of most of these changes, and to accept many of them.

Specifically, about two-thirds or more of the American public consider changes that would require employees to pay a part of their health insurance premiums, that would increase the deductible, and that would prevent the dual-filing of claims for the same medical services to be effective cost-containment strategies. Although not overly enthusiastic about these changes, significant majorities (58% to 67%) of the public are willing to accept them.

On the other hand, although about two-thirds of the public recognize the proposal to increase copayments as an effective strategy, the sample is evenly split on its acceptability.

While the opinions of union leaders generally parallel those of the American public on the deductibles, copayments, and dual-filing of claims issues, this group is evenly split on the acceptability of the proposal to require employees to pay part of the insurance premiums. Majorities of respondents in all the other professional groups endorse these changes in terms of both effectiveness and acceptability.

The proposal to tax a portion of the employer-paid insurance premium is generally considered ineffective and unacceptable by more than two-thirds of the insurance executives, corporate benefits officers, and union leaders, and by about half of the hospital administrators and the American public. Relative to the other groups, physician leaders are most likely (62%) to find this suggestion acceptable.

Observation:
The finding that most of the respondents find the tax on insurance premiums an ineffective cost control strategy is clearly logical in view of the fact that this policy, unlike the others, does not provide any incentive for lower utilization of nonessential health care services.

- **Proposed changes in insurance plans that provide a lower-cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures**

Majorities of the American public recognize that all these proposed changes are likely to be effective in containing health care costs and the public is generally (though not overwhelmingly) willing to accept these measures. Physician leaders are notably resistant to recognizing them as either effective or acceptable cost-containment strategies. It should be noted that many of these proposals imply competition between health care providers and involve a potential loss of income.

Requiring the patient to get a second opinion in the case of non-emergency surgery is seen as an effective cost-containment proposal as well as an acceptable one by large majorities (70% to 93%) of the American public and of all the professional groups *except* physician leaders. Although 63% of the physician leaders find this proposal acceptable, a minority (32%) consider it effective.

Prepaid health care plans (e.g., health maintenance organizations) are most likely to be viewed as effective by union leaders (73%); they are seen as somewhat less effective by the public, corporate and insurance executives (59% to 68%), and they are least likely to be seen as effective by physician leaders (34%) and hospital administrators (49%). The acceptability of prepaid plans is similarly lowest among physician leaders (37%) and highest among union leaders (77%).

Although precertification (prior payment approval) of nonemergency hospitalization by insurance companies is recognized as an effective cost-containment strategy by significant majorities (58% to 89%) in all groups interviewed, it is generally considered acceptable by fewer people in each group, particularly among physician leaders (34%) and hospital administrators (47%). A sizable minority of the American public (41%) consider this proposal unacceptable.

At least 70% of the American public feel that changes that require the use of a designated primary care physician, that include only health care providers with lower prices in an insurance plan, or that provide incentives such as lower out-of-pocket costs to patients who use designated providers ("preferred provider") are effective cost-containment strategies. However, acceptability to the public of these proposals is not as high (69%, 62%, and 61%, respectively). Generally, the primary care physician and preferred provider proposals are viewed as more effective and acceptable by all professional groups than are restricting coverage to providers with lower prices. Physician leaders stand out in that they are more likely than all the other professional groups to find all of these proposals unacceptable.

A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians is considered an effective cost-containment strategy by majorities of the American public (64% to 93%) and all professional groups except the physician leaders (30%). Sizable minorities of the American public (35%) and hospital administrators (40%) find this proposal unacceptable, while the majority of physician leaders (75%) say it is unacceptable to them.

- **Proposals that suggest providing incentives for health maintenance and preventive care**

Majorities of the American public and in all the professional groups (76% to 82%) agree that insurance plans that offer incentives to people who practice health and safety procedures are likely to be effective in containing health care costs. Even greater majorities (79% to 97%) find this proposal acceptable. This is not surprising when one considers the fact that this is one of the few proposals that does not imply reduced income for providers or increased cost — financial or otherwise — to consumers.

Surprisingly, all professional groups except union leaders view the proposal for "insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target" as acceptable and effective. While 62% of the union leaders find this proposal acceptable, they are about evenly split with respect to its expected effectiveness in containing costs.

- **Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options**

Vast majorities in all groups (81% to 99%), including hospital administrators, believe that having tests and minor surgery done in clinics and doctors' offices rather than in hospitals, or treating the chronically ill at home instead of in hospitals and nursing homes are effective cost-containment strategies. Similarly, overwhelming majorities of respondents in all groups consider these proposals acceptable.

Particularly impressive is the open-mindedness displayed by the hospital administrators, whose institutions would clearly be affected by these proposals.

- **Proposals to place constraints on prices of health care services and equipment purchase and use**

While the American public and most of the professional groups recognize the efficacy of constraints on prices, equipment purchase, and utilization and consider these constraints acceptable, physician leaders are generally unaccepting of these constraints. By contrast, again, the majority of hospital administrators are willing to accept these constraints.

While more than three-quarters of the American public believe that diagnosis-related fixed prices would be an effective as well as acceptable means of cost containment, only 51% of the physician leaders view this proposal as effective, and still fewer (32%) consider it acceptable. The physician leaders' views also contrast remarkably with those of hospital administrators, majorities of whom (84%) recognize the effectiveness of this proposal and are willing to accept it (71%). The other professional groups are largely supportive (more than 70%) of this proposal.

Majorities in all of the other professional groups except union leaders find the idea of government price controls of doctors' and hospital fees generally both unacceptable and ineffective.

With regard to the proposal to curb unrestrained purchase of expensive equipment at hospitals, there is clear recognition of its merit as a cost-containment measure by the American public and by all of the professional groups. Physician leaders, however, are least likely (58%) to recognize that reducing the duplication of expensive equipment and specialists at hospitals close to each other would be an effective cost-containment strategy. Astonishingly, this proposal is considered acceptable by fewer physician leaders (51%) than hospital administrators (73%).

Limiting the use of expensive medical technology for patients with virtually no hope of recovery is a proposal that, although generally recognized as an effective cost-containment strategy by all groups, is considered acceptable by less than half of the respondents in all groups except physician leaders, 59% of whom consider it acceptable.

Business coalitions formed to reduce health care costs are viewed as both effective and acceptable by large majorities of all professional groups. Utilization reviews by third-party payers are viewed as effective by sizable majorities in all groups, and they are more acceptable to insurance executives (96%), corporate benefits officers (93%), and union leaders (80%) than they are to hospital administrators (66%) and physician leaders (52%). It appears that the physician leaders generally are unwilling to accept any price constraints on or review of their practice of medicine.

- **Proposed changes in malpractice and antitrust laws**

The physician leaders overwhelmingly support the changing of laws that encourage doctors to practice defensive medicine to protect themselves from malpractice suits. This proposal is also viewed as both effective and acceptable by all of the professional groups.

On the other hand, the proposal to change antitrust laws to allow third-party payers to join together and

negotiate costs with health care providers meets with a mixed reaction. Large majorities among union leaders, corporate benefits officers, and insurance executives (88% to 96%) consider this proposal both effective and acceptable. Smaller majorities of physician leaders (69%) and hospital administrators (77%) consider it effective, but their views on its acceptability contrast sharply. Whereas only 47% of physician leaders find it acceptable, 69% of hospital administrators do so.

Table 3-1

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs* or *discouraging use* of nonessential services?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
In the case of non-emergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary						
Very effective	58	5	29	32	46	54
Somewhat effective	27	27	42	38	44	19
Not very/not at all effective	14	68	28	28	10	27
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals						
Very effective	57	56	50	62	77	65
Somewhat effective	30	38	37	34	22	27
Not very/not at all effective	12	6	11	4	1	8
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes						
Very effective	49	50	58	56	62	46
Somewhat effective	32	39	34	38	34	46
Not very/not at all effective	16	10	7	6	4	4
Insurance plans that offer incentives to people who practice health and safety procedures -- such as non-smokers, seatbelt users, or those who are not overweight						
Very effective	44	30	30	34	25	35
Somewhat effective	35	52	50	42	53	42
Not very/not at all effective	19	18	19	22	20	16

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services						
Very effective	42	30	40	54	52	46
Somewhat effective	30	38	41	34	31	23
Not very/not at all effective	24	29	14	12	14	23
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed						
Very effective	38	8	32	28	27	35
Somewhat effective	40	43	52	52	54	38
Not very/not at all effective	18	45	13	20	16	20
Government price controls of doctors' and hospital fees						
Very effective	38	13	18	14	15	58
Somewhat effective	29	33	26	18	28	19
Not very/not at all effective	29	52	52	68	55	20
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians						
Very effective	35	3	25	22	27	35
Somewhat effective	38	27	39	46	56	58
Not very/not at all effective	25	67	35	30	17	8
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby						
Very effective	35	15	32	52	51	46
Somewhat effective	32	43	47	36	38	27
Not very/not at all effective	31	41	20	10	11	23

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services						
Very effective	33	51	37	52	56	39
Somewhat effective	36	37	43	42	40	35
Not very/not at all effective	28	10	19	4	4	24
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery						
Very effective	33	38	35	32	23	27
Somewhat effective	30	48	42	48	46	35
Not very/not at all effective	31	11	19	18	28	27
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient						
Very effective	32	11	33	44	36	38
Somewhat effective	44	53	50	44	53	46
Not very/not at all effective	21	35	15	10	11	15
Requiring employees to pay a part of their health insurance premiums						
Very effective	31	35	33	34	38	27
Somewhat effective	36	49	41	38	41	23
Not very/not at all effective	30	15	25	28	21	46

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses						
Very effective	29	45	36	50	58	35
Somewhat effective	37	42	45	42	38	31
Not very/not at all effective	31	11	17	8	4	27
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization						
Very effective	28	15	18	50	51	38
Somewhat effective	39	43	46	34	38	23
Not very/not at all effective	30	41	34	14	11	34
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services						
Very effective	27	5	16	32	22	35
Somewhat effective	32	29	33	26	46	38
Not very/not at all effective	37	64	49	42	31	27
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive						
Very effective	24	8	15	28	26	31
Somewhat effective	48	43	46	52	49	46
Not very/not at all effective	24	47	38	20	22	23

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list						
Very effective	24	9	25	44	28	27
Somewhat effective	46	49	53	48	57	50
Not very/not at all effective	26	39	22	8	13	23
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds $840 for the individual and $2,100 for the family						
Very effective	18	15	16	2	4	19
Somewhat effective	28	41	29	20	22	12
Not very/not at all effective	47	40	50	78	72	66
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits						
Very effective	x	40	35	38	34	31
Somewhat effective	x	45	43	38	43	46
Not very/not at all effective	x	14	18	24	22	20
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target						
Very effective	x	25	26	30	22	19
Somewhat effective	x	55	49	44	52	35
Not very/not at all effective	x	19	22	26	25	46

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders						
Very effective	x	12	29	50	47	46
Somewhat effective	x	57	48	44	42	50
Not very/not at all effective	x	29	19	6	9	-
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs						
Very effective	x	21	28	40	45	46
Somewhat effective	x	57	59	50	50	50
Not very/not at all effective	x	20	12	8	5	4
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures						
Very effective	x	18	25	42	44	27
Somewhat effective	x	44	49	40	49	54
Not very/not at all effective	x	37	25	14	7	8

x = Not asked

Table 3-2

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* personally/as a professional in this field?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
In the case of non-emergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary						
Very acceptable	64	27	46	54	64	58
Somewhat acceptable	24	36	38	38	29	23
Not very/not at all acceptable	10	37	15	8	6	19
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals						
Very acceptable	56	67	55	70	83	58
Somewhat acceptable	27	32	29	26	14	23
Not very/not at all acceptable	16	1	13	4	2	20
Insurance plans that offer incentives to people who practice health and safety procedures — such as non-smokers, seatbelt users, or those who are not overweight						
Very acceptable	52	75	63	56	45	46
Somewhat acceptable	28	22	29	34	34	38
Not very/not at all acceptable	18	2	7	8	20	12
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes						
Very acceptable	46	66	60	62	57	46
Somewhat acceptable	32	25	31	34	36	38
Not very/not at all acceptable	20	7	8	4	8	12

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services						
Very acceptable	40	59	65	60	49	66
Somewhat acceptable	27	21	15	22	22	15
Not very/not at all acceptable	29	19	16	18	26	12
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed						
Very acceptable	37	6	27	32	26	38
Somewhat acceptable	39	26	44	52	50	35
Not very/not at all acceptable	21	67	27	16	23	19
Government price controls of doctors' and hospital fees						
Very acceptable	34	1	10	6	13	50
Somewhat acceptable	27	6	11	14	14	15
Not very/not at all acceptable	36	90	74	78	70	27
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby						
Very acceptable	32	18	43	58	54	62
Somewhat acceptable	30	33	30	26	30	12
Not very/not at all acceptable	36	47	25	16	15	24
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians						
Very acceptable	29	4	24	30	28	31
Somewhat acceptable	34	20	35	48	45	42
Not very/not at all acceptable	35	75	40	20	26	23

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring employees to pay a part of their health insurance premiums						
Very acceptable	29	54	45	42	45	27
Somewhat acceptable	36	35	36	36	32	19
Not very/not at all acceptable	32	10	18	22	22	50
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services						
Very acceptable	29	6	23	32	25	35
Somewhat acceptable	32	31	43	38	42	42
Not very/not at all acceptable	36	61	33	30	33	23
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient						
Very acceptable	29	11	40	46	32	31
Somewhat acceptable	40	37	40	38	51	38
Not very/not at all acceptable	29	52	19	14	17	27
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery						
Very acceptable	25	24	20	8	9	12
Somewhat acceptable	24	35	28	20	27	27
Not very/not at all acceptable	46	38	49	72	61	50

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services						
Very acceptable	24	58	41	46	56	27
Somewhat acceptable	34	31	38	42	34	38
Not very/not at all acceptable	39	10	20	12	10	35
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive						
Very acceptable	22	7	11	18	12	19
Somewhat acceptable	40	24	34	32	30	46
Not very/not at all acceptable	34	68	53	48	56	35
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list						
Very acceptable	22	6	31	44	24	19
Somewhat acceptable	39	35	37	42	45	58
Not very/not at all acceptable	36	58	32	14	31	20
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization						
Very acceptable	22	7	13	34	38	23
Somewhat acceptable	35	27	34	36	38	38
Not very/not at all acceptable	41	66	51	28	23	38

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses						
Very acceptable	19	48	33	42	49	19
Somewhat acceptable	33	34	43	40	36	27
Not very/not at all acceptable	46	17	22	18	14	46
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds $840 for the individual and $2,100 for the family						
Very acceptable	14	25	20	4	4	12
Somewhat acceptable	25	37	31	18	16	8
Not very/not at all acceptable	56	36	43	82	78	77
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs						
Very acceptable	x	37	43	74	69	65
Somewhat acceptable	x	48	44	24	30	23
Not very/not at all acceptable	x	15	12	2	1	12
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures						
Very acceptable	x	15	35	60	57	42
Somewhat acceptable	x	37	31	36	36	38
Not very/not at all acceptable	x	47	33	2	6	8

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders						
Very acceptable	x	13	30	58	56	62
Somewhat acceptable	x	34	39	30	32	27
Not very/not at all acceptable	x	52	27	12	9	8
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits						
Very acceptable	x	61	49	52	41	35
Somewhat acceptable	x	25	28	24	32	42
Not very/not at all acceptable	x	12	20	24	26	20
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target						
Very acceptable	x	49	47	40	36	27
Somewhat acceptable	x	40	41	44	43	35
Not very/not at all acceptable	x	10	10	16	21	39

x = Not asked

Views of Those Corporate Benefits Officers Whose Companies Have Had Experience With Specific Cost-Containment Programs

Experience with a cost-containment program does not necessarily increase the program's likelihood of being endorsed as effective. However, some programs are clearly working well, because those benefits officers who have had experience with certain programs give those programs more favorable ratings than do those who have had no experience.

Table 3-3 presents the data on the anticipated effectiveness of each of selected cost-containment programs as judged by corporate benefits officers whose companies have had experience with the program compared with those whose companies have not had experience with the program. (Only those programs with which at least 20% of the respondents have had experience were analyzed in this manner.)

The data reveal that experience with the following programs generally correlates positively with views that the programs are "very effective" in cost containment:

- "Requiring employees to pay a part of their health insurance premiums";
- "Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services";
- "Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures";
- "Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes"; and
- "A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians."

Table 3-3

EFFECTIVENESS OF COST-CONTAINMENT PROGRAMS AS JUDGED BY BENEFITS OFFICERS AT COMPANIES WITH EXPERIENCE WITH EACH PROGRAM[1]

Base: Corporate benefits officers

Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs* or *discouraging use* of nonessential services?

	Total	Has Experience With Program	No Experience With Program
No. of Respondents	250	Varies[2]	Varies[3]
	%	%	%
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals			
Very effective	77	79	75
Somewhat effective	22	20	23
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes			
Very effective	62	72	55
Somewhat effective	34	25	40
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses			
Very effective	58	62	54
Somewhat effective	38	35	41
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services			
Very effective	56	59	52
Somewhat effective	40	40	40
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services			
Very effective	52	71	36
Somewhat effective	31	22	38
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary			
Very effective	46	51	42
Somewhat effective	44	42	45

Continued

Table 3-3 (Continued)

EFFECTIVENESS OF COST-CONTAINMENT PROGRAMS AS JUDGED BY BENEFITS OFFICERS AT COMPANIES WITH EXPERIENCE WITH EACH PROGRAM[1]

Base: Corporate benefits officers

	Total	Has Experience With Program	No Experience With Program
No. of Respondents	250	Varies[2]	Varies[3]
	%	%	%
The health care coalitions of businesses and employers in particular cities or areas where they work together to reduce costs			
Very effective	45	42	47
Somewhat effective	50	51	50
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures			
Very effective	44	51	36
Somewhat effective	49	44	53
Requiring employees to pay a part of their health insurance premiums			
Very effective	38	45	24
Somewhat effective	41	38	46
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient			
Very effective	36	40	33
Somewhat effective	53	48	56
A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians			
Very effective	27	38	24
Somewhat effective	56	58	55
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services			
Very effective	22	21	23
Somewhat effective	46	58	39

1
Only those programs with which at least 20% of the respondents' companies have experience are reported in this table (see Table 4-1).

2
The bases for those corporate benefits officers who have had experience vary — with the first program listed having the highest base (162) and the last one having the lowest (53).

3
The bases for those corporate benefits officers who have had no experience also vary — with the first program listed having the lowest base and the last one having the highest.

Attitudes Toward Proposed Trade-offs in Health Care Coverage

The American public is not entirely unanimous about the fairness of the proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others.

Sixty-seven percent consider as fair and reasonable the proposal for better insurance coverage for tests conducted without hospitalization than for tests that involve overnight hospitalization; however, only 51% consider a similar proposal regarding surgery to be fair and reasonable (Table 3-4). Similarly, more union leaders (92%) consider the former fair and reasonable than view the latter as such (50%). More than 75% of the respondents in the other professional groups — physician leaders, hospital administrators, insurance executives, and corporate benefits officers — consider both proposed trade-offs fair and reasonable.

The proposal to require higher deductibles and copayments while adding dental and visions benefits to a health care plan is considered fair and reasonable by 65% of the American public and 58% of union leaders. Compared with the other four proposals, this one is considered fair and reasonable by the lowest number of respondents in the other professional groups, particularly among physician leaders and hospital administrators.

A trade-off requiring higher deductibles and initial cost-sharing for better coverage of longer-term treatment is considered fair and reasonable by more than 80% of all professional groups except union leaders, only 50% of whom consider it so. A majority of the American public (61%) consider this proposal fair.

The American public, like union leaders, displays a split in its opinion about the fairness of paying a larger share of the cost of emergency room care while getting better coverage for treatment at doctors' offices. Clear majorities in the other professional groups consider this trade-off to be fair and reasonable.

Table 3-4

TRADE-OFFS IN HEALTH CARE COVERAGE CONSIDERED FAIR AND REASONABLE

Q. I will read you some proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others. For each one, please tell me if you think the trade-off is fair and reasonable.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Providing better coverage for tests conducted without hospitalization than for tests involving overnight hospitalization						
Yes, is fair and reasonable	67	87	77	92	94	92
No, isn't fair and reasonable	28	12	21	8	6	8
Requiring higher deductibles and copayments but adding dental and vision benefits in the health care plan						
Yes, is fair and reasonable	65	55	60	74	73	58
No, isn't fair and reasonable	30	43	38	26	22	35
Requiring higher deductibles and copayments for the initial cost of health care, but with better coverage for the cost of longer-term treatment						
Yes, is fair and reasonable	61	96	84	86	92	50
No, isn't fair and reasonable	34	2	14	12	6	42
Requiring a patient to pay a larger share of the cost of care obtained at hospital emergency rooms, but with better coverage for treatment at the doctor's office						
Yes, is fair and reasonable	52	83	72	84	79	46
No, isn't fair and reasonable	44	14	26	16	20	42
Requiring patients to pay a larger share of the cost of overnight hospital stays, but providing better coverage for surgery that does not involve hospitalization						
Yes, is fair and reasonable	51	80	76	84	88	50
No, isn't fair and reasonable	44	17	23	16	11	42

CHAPTER 4: EXPERIENCE AND POLICIES OF CORPORATIONS AND UNIONS REGARDING HEALTH CARE PROGRAMS

Experience With Specific Cost-Containment Programs

Corporate benefits officers and union leaders were asked to indicate whether or not they had had any experience with each of several cost-containment policies and programs discussed in Chapter 3. Table 4-1 summarizes their responses.

Majorities of corporations have had experience with programs that require greater cost-sharing (premiums, deductibles, copayments) from the patient, with those that discourage the use of hospitals for tests and minor surgery, and with business coalitions and prepaid (HMO-type) health care programs.

The majority of unions, on the other hand, have had experience with prepaid health care, discouraging the filing of dual claims for the same services, and requiring second opinions on nonemergency surgery. Only about one-third of unions have had experience with increased direct cost-sharing by their members.

Table 4-1

ORGANIZATIONS' EXPERIENCE WITH COST-CONTAINMENT PROGRAMS

Base: Corporate benefits officers and union leaders only

Q. I am going to read you a list of some of the programs and policies again. This time, please tell me if your organization has had any experience with each one, or not.

No. of Respondents	Corporate Benefits Officers 250	Union Leaders 26
	%	%
Requiring employees to pay a part of their health insurance premiums	65	38
The health care coalitions of businesses and employers in particular cities or areas where they work together to reduce costs	64	27
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals	63	42
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services	61	38
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services	58	62

Continued

Table 4-1 (Continued)

ORGANIZATIONS' EXPERIENCE WITH COST CONTAINMENT PROGRAMS

Base: Corporate benefits officers and union leaders only

	Corporate Benefits Officers	Union Leaders
No. of Respondents	**250**	**26**
Requiring patients to pay a *greater* part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses	54	31
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary	51	69
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures	41	35
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services	41	65
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes	39	35
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient	34	38
A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians	21	35
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization *prior* to nonemergency hospitalization	14	27
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list	11	23
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed	10	42
Insurance plans that offer incentives to people who practice health and safety procedures — such as nonsmokers, seatbelt users, or those who are not overweight	8	8
Including only hospitals and doctors with lower prices in a health insurance plan, and *excluding* those that are more expensive	4	15
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target	4	8

Review of Health Care Benefits

While 92% of the corporate benefits officers report that their organizations reviewed their health care benefits during the past year with the objective of reducing costs, only 69% of union leaders report that their organization did so (Table 4-2).

Table 4-2

MOST RECENT REVIEW OF HEALTH CARE BENEFITS

Base: Corporate benefits officers and union leaders

Q. When was the last time your organization reviewed its health care benefits with the objective of reducing costs? Was it within the past year, one to two years ago, or more than two years ago?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
	%	%
Within the past year	92	69
1 to 2 years ago	5	12
More than 2 years ago	3	15
Not sure	*	4

*Less than 0.5%

Cost-Sharing With Employees or Union Members

Table 4-3 presents data on the relative number of corporations and unions that require their employees or members to share the cost of health care coverage and services. Clearly, corporations are more demanding of their employees on this matter than are unions.

Table 4-3

COST-SHARING WITH EMPLOYEES OR UNION MEMBERS

Base: Corporate benefits officers and union leaders

Q. Do you require your (employees/union members) to pay (READ EACH ITEM)?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
	%	%
A part of the premium		
Yes, require	53	15
No, don't require	44	73
A deductible		
Yes, require	95	69
No, don't require	4	27
Copayments		
Yes, require	88	35
No, don't require	9	54

Administration of Claims Payments

While 24% of the corporations use a third-party administrator for claims payments, only 12% of the unions do so. Corporations primarily rely on their insurance carrier to handle claims payments, while unions administer them within their own organization (Table 4-4).

Of the 60 corporate benefits officers whose companies use third-party administrators, 52% believe that the administrators are better able to control costs than they themselves or their insurance carrier are (Table 4-5). The reasons given for this are as expected: "They have more expertise and experience...they are more objective and impartial...they save us money...they have better access to insurance information...we don't have the personnel resources for it."

Table 4-4

ADMINISTRATION OF CLAIMS PAYMENTS

Base: Corporate benefits officers and union leaders

Q. Who is responsible for the administration of claims payments for your organization's health care plan? Is it a person or department within your organization, your insurance carrier, a third-party administrator, or someone else?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
	%	%
A person or department within your organization	22	46
Your insurance carrier	53	38
A third-party administrator	24	12

Table 4-5

OPINIONS ON THE ABILITY OF THIRD-PARTY ADMINISTRATORS TO CONTROL COSTS

Base: Coporate benefits officers and union leaders

Q. In your view, are third-party administrators better able to control an organization's health care costs than you yourself or insurance companies can?

	No. of Respondents	Yes, Are Better Able	No, Aren't Better Able
Corporate Benefits Officers			
Use third-party administrators	60	52	43
Do not use third-party administrators	188	17	67
Union Leaders			
Use third-party administrators	3	x	x
Do not use third-party administrators	22	23	73

x = The base for this group is too small for meaningful analysis through a computation of percentages

Self-Funded and Cafeteria-Style Benefits

Self-funded insurance plans and cafeteria-style benefit programs are two means that corporations can use to control the administrative costs of providing health care benefits to their employees.

While 78% of corporations surveyed have a self-funded insurance plan (Table 4-6), and 70% of them have had that plan for more than three years, cafeteria-style benefits are still very rare. Only 7% of the corporate benefits officers report that their companies offer them (Table 4-7).

Of the 56 companies that have had a self-funded plan for three years or less, 75% report that it has resulted in more overall cost savings, in terms of real dollars, than the plan they had before. Furthermore, 82% of these companies have become more conscious of the amount paid out under this type of health plan.

When asked whether they think cafeteria-style benefits are effective in controlling health care costs, 58% of corporate benefits officers answer in the affirmative; 31% think they are not effective (Table 4-8). This suggests that perhaps more companies may be willing to try this approach. (Although not reported in tabular form, the survey reveals that 68% of the companies who do not have cafeteria-style benefits have considered offering them.)

Table 4-6

SELF-FUNDED INSURANCE PLANS

Base: Corporate benefits officers

Q. Does your company have a self-funded insurance plan?

	Corporate Benefits Officers
No. of Respondents	**250**
	%
Yes, has plan	78
No, doesn't have plan	18
Not sure	3

Table 4-7

CAFETERIA-STYLE BENEFITS

Base: Corporate benefits officers

Q. Does your company offer its employees cafeteria-style benefits in which your company allows employees to choose among all benefits?

	Corporate Benefits Officers
No. of Respondents	250
	%
Yes, offers	7
No, doesn't offer	93
Not sure	*

*Less than 0.5%.

Table 4-8

PERCEIVED EFFECTIVENESS OF CAFETERIA-STYLE BENEFITS IN CONTROLLING HEALTH CARE COSTS

Base: Corporate benefits officers

Q. Do you think cafeteria-style benefits are very effective, somewhat effective, not very effective, or not at all effective in controlling the cost of health care?

	Corporate Benefits Officers
No. of Respondents	250
	%
Very effective	7
Somewhat effective	51
Not very effective	23
Not at all effective	8
Not sure	10

CHAPTER 5: OPINIONS ON COST-SHIFTING AND HEALTH CARE COVERAGE FOR THE UNEMPLOYED

Shifting Costs From Medicare and Medicaid Patients to Other Patients

Majorities of respondents in all groups disapprove of doctors and hospitals charging higher fees for patients who pay their own bills or are covered by private insurance than for Medicare and Medicaid patients (Table 5-1).

Surprisingly, 22% of the American public approve of this "cost-shifting." What is even more surprising is that these 22% are not primarily Medicare and Medicaid recipients (Table 5-2). The only subgroup of the American public that disapproves of cost-shifting in a relatively larger proportion than the others is the subgroup with no insurance coverage.

Table 5-1

ATTITUDES TOWARD MEDICARE AND MEDICAID "COST-SHIFTING": THE PUBLIC AND PROFESSIONALS COMPARED

Q. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance. Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	**1501**	**100**	**100**	**50**	**250**	**26**
	%	%	%	%	%	%
Approve	22	5	7	10	10	12
Do not approve	74	95	87	90	90	77
Not sure/no opinion	4	-	5	-	-	8

Table 5-2

ATTITUDES TOWARD MEDICARE AND MEDICAID "COST-SHIFTING": THE PUBLIC BY INSURANCE COVERAGE

Base: Public cross section

Q. The two main government health care programs paid for out of taxes are Medicare, which is mainly for people 65 and over, and Medicaid, which is for people with low incomes. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance. Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

		Type of Health Care Coverage				
	Total	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1016	300	94	687	75
	%	%	%	%	%	%
Approve	22	23	17	20	24	15
Do not approve	74	73	76	75	73	81
Not sure/no opinion	4	4	6	5	3	3

Attitudes Toward Health Care Coverage for the Unemployed

The American public appears to agree in principle with the idea of a health care program for the unemployed, but they are reluctant to be in favor of such a program if it means a higher direct or indirect cost to themselves.

The American public was presented with four proposals for financing health coverage for the unemployed. The proposal favored by more of the public than any other is one that requires employers to maintain benefits for laid-off workers for six months and to contribute in some form toward providing another twelve months' coverage.

Whereas 65% favor financing health care coverage for the unemployed at the state government level and 59% favor financing at the federal government level, only 42% favor financing such a program from new taxes on individuals' employer-paid health insurance premiums (Table 5-3).

As would be expected, the unemployed favor all the proposals to a greater extent than do those who are not unemployed (Table 5-4). However, 55% of the unemployed group do not favor such programs if it means higher direct or indirect cost to other people (Table 5-6). In fact, those employed full-time (45%) or retired (44%) are more likely to favor such a program, despite cost to themselves.

Among the professional groups, the union leaders are most likely to favor all proposed programs for financing health care for the unemployed, except through taxes on premiums, even at cost to other people (Tables 5-3 and 5-4).

At the other extreme are corporate benefits officers, majorities of whom do not favor any of the proposals. The other three professional groups favor extension of employer-paid benefits or financing at the state government level more than they do financing at the federal government level or through taxes on premiums. In fact, majorities in these three groups clearly do not favor the latter two proposals. These three groups resemble union leaders in that they favor health care coverage for the unemployed despite cost to others. (Table 5-5).

The idea of establishing a tax on third-party payers to finance extension of benefits to the unemployed is in clear disfavor among all professional groups except union leaders, who are evenly split on the issue.

Observation
If a program is established to provide health care coverage for the unemployed, then its costs will clearly be passed on to the American public, directly or indirectly. Despite this, it is impressive to see that a little over 40% of the public favor such a program. There is indeed "no free lunch" and people seem to recognize that.

Table 5-3

ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED: THE PUBLIC AND PROFESSIONALS COMPARED

Q: One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage						
Favor	71	57	47	58	34	77
Do not favor	27	41	51	40	66	19
Not sure/no opinion	2	1	2	2	*	4
Encouraging but not requiring each state to pay for health care coverage for unemployed workers						
Favor	65	61	63	52	42	69
Do not favor	33	37	36	48	57	31
Not sure/no opinion	2	-	1	-	1	-
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program						
Favor	59	36	29	20	22	77
Do not favor	38	62	69	80	77	19
Not sure/no opinion	2	-	2	-	1	4
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount						
Favor	42	41	30	28	13	35
Do not favor	54	57	66	72	86	62
Not sure/no opinion	4	2	4	-	1	4
Establishing a tax on third-party payers to finance extension of benefits for the unemployed						
Favor	x	27	16	14	11	42
Do not favor	x	72	82	86	87	46
Not sure/no opinion	x	1	2	-	1	12

*Less than 0.5%.
x = Not asked

Table 5-4

ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED: THE PUBLIC BY OCCUPATIONAL STATUS

Base: Public cross section

Q. One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

		Occupational Status				
	Total	Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
	%	%	%	%	%	%
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage						
Favor	71	70	71	68	81	71
Do not favor	27	28	29	27	17	26
Encouraging but not requiring each state to pay for health care coverage for unemployed workers						
Favor	65	62	66	65	77	65
Do not favor	33	36	33	30	20	32
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program						
Favor	59	55	56	62	81	60
Do not favor	39	43	41	34	17	34
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount						
Favor	42	36	43	47	57	39
Do not favor	54	59	53	45	38	58

Table 5-5

ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED DESPITE COST TO OTHERS: THE PUBLIC AND PROFESSIONALS COMPARED

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Favor	43	67	58	66	42	73
Do not favor	53	28	38	34	55	19
Not sure/no opinion	3	4	4		3	4

Table 5-6

ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED DESPITE COST TO OTHERS: THE PUBLIC BY OCCUPATIONAL STATUS

Base: Public cross section

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

		Occupational Status				
	Total	Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
	%	%	%	%	%	%
Favor	43	45	39	44	39	37
Do not favor	53	53	58	50	55	58
Not sure/ no opinion	3	2	3	5	6	4

APPENDIX A: SURVEY METHOD

Sample Design

Six different samples were surveyed in this study. The sample design for each is detailed below.

1. The American Public:

A nationwide cross section of 1,501 adults, 18 years or over, was interviewed for this study. The sample was generated by the random-digit-dialing method and was based on an unclustered sampling frame, stratified by region and by the Census Bureau's "size of place" designations.

2. Physician Leaders:

100 interviews were completed with physicians who represent the leadership of state, local, and specialty medical societies throughout the nation. A random selection procedure was used to draw this sample from the 1981 AMA directory of officials and staff.

3. Hospital Administrators:

100 hospital administrators were interviewed. A sample of hospitals and their administrators was drawn from the *American Hospital Association Guide*, 1981 edition. The sample selection procedure involved selecting the largest hospital from each region in the directory to assure national representation.

4. Health Insurance Executives:

50 interviews were completed with senior health insurance executives of the larger insurance companies with group health lines. The sample was drawn from three sources:

- Blue Cross/Blue Shield plans with memberships of 1,000,000 or more for regular group plans.
- Insurance companies from the Fortune 50 list (1982) who have accident and health insurance (SIC: 6321) and hospital and medical service (SIC: 6324) plans.
- Companies listed in SIC's 6321 and 6324 of the *Dun & Bradstreet Million Dollar Directory*.

5. Corporate Benefits Officers:

250 interviews were completed with corporate benefits officers responsible for and knowledgeable about their companies' health care plans. A random selection procedure was used to draw the sample from the 1982 Fortune 1,000 list of industrial companies and the list of 50 nonindustrials in all categories, excluding insurance companies and utilities.

6. Union Leaders:

26 interviews were completed with leaders within major trade unions who had primary responsibility for health care benefits. The sample was drawn from a list of labor unions found in the 1983 National Trade and Professional Associations directory. To ensure that the large unions were represented, those with an operating budget of more than 5,000,000 were selected first, and then a random selection procedure was used to select from unions with operating budgets of from $2,500,000 to $5,000,000.

Interviewing

Interviews were conducted by telephone from May 13 through June 7, 1983. The public sample was interviewed from 5:00 p.m. to 10:00 p.m. (local time) on weekdays, and from 10:00 a.m. to 10:00 p.m. (local time) on weekends. The professional samples (items numbered 2 through 6 above) were interviewed on weekdays from 9:00 a.m. to 5:00 p.m. Where necessary, appointments were made to interview the relevant individual within the organization contacted.

Up to three callback attempts were made to reach the selected respondent. On the average, the interviews with the public sample lasted 32 minutes, and those with professional groups lasted 27 minutes.

The response rates were: 57% for the public sample, 78% for the sample of physician leaders, and 83% across the other professional groups.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates.

Codes were developed for responses to open-end questions, with only those responses given by less than 0.2% of the respondents being coded as "other" responses.

The data were analyzed and tabulated separately for each of the six samples. The responses given by the public sample were cross-tabulated against the following variables:

- Total sample;
- Region;
- Sex;
- Employment status;
- Income;
- Labor union family;
- Age;
- Ethnicity;
- Family size;
- Political philosophy;
- Health care coverage through self or family;
- Health status;
- Type of health coverage;
- Contribution to insurance premium;
- Those who did not get needed medical help;
- Number of outpatient visits by any member of the family; and
- Overnight hospital stay by any member of the family.*Weighting of the Data*

Weighting of the Data

The data from the public sample were weighted to be representative of the population of U.S. households. The weights were based on the 1980 census counts for age, race, sex and income.

Sampling Error

The table below indicates the sampling error associated with the various sample sizes and the reported sample percentages at the *95% confidence level:*

	Reported Sample Percentage				
Sample Size	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
1500	1.5	2.0	2.3	2.5	2.5
250	3.7	4.9	5.6	6.1	6.2
100	5.9	7.8	8.9	9.6	9.8
50	8.3	11.1	12.7	13.6	13.8

1 It should be noted that the professional group samples were drawn from small and defined universes. Therefore, the effective sampling error for these samples would be considerably smaller than the ones reported in this table.

Thus, if a reported sample percentage of 40% is based on a sample of 1,500 cases (e.g., the public sample), then the 95% confidence interval containing the population percentage is 40 ± 2.5 or 37.5% to 42.5%.

Copies of the questionnaires used in this study are available upon request from Louis Harris and Associates.

APPENDIX B: PROFILES OF THE PUBLIC SAMPLE

Profiles of the Public Sample

Table B-1 presents the demographic profile of the survey sample of the American public.

Table B-2 presents the weighted data on the type of health care coverage reported by the total sample and categorized by employment status.

Table B-3 presents the weighted data on the usage of health care facilities by the total sample, those in excellent or good health versus those in poor or fair health, and those with different types of health care coverage.

Table B-1

DEMOGRAPHIC PROFILE OF THE PUBLIC SAMPLE

	Unweighted	Weighted
	%	%
Total	100	100
Region[1]		
Northeast	23	23
North Central	27	27
South	32	32
West	18	18
Sex		
Male	48	47
Female	52	53
Employment Status		
Employed full-time	53	51
Employed part-time	11	11
Retired	18	19
Unemployed	6	6
Student/housewife	12	12
Income		
$7,500 or less	12	14
$7,501 to $15,000	17	18
$15,001 to $25,000	27	21
$25,001 to $35,000	20	18
$35,001 or more	18	22
Age		
18-29 years	27	30
30-39 years	24	20
40-49 years	14	13
50-64 years	20	21
65 and over	15	16
Ethnicity		
White	83	84
Black	9	10
Hispanic	6	6
Family Size		
1	17	17
2	30	30
3	20	20
4 or more	32	32
Political Philosophy		
Conservative	38	38
Middle-of-the-road	39	39
Liberal	17	17

1 Definition of geographic regions

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

North Central: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin

South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Table B-2

TYPE OF HEALTH CARE COVERAGE

Q. Now I'd like to talk about the different kinds of health plans or health insurance that people have, including those provided by the government. As I read each of the following health plans, please tell me whether or not you are covered by it.

		Occupational Status				
	Total	Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
	%	%	%	%	%	%
Health insurance through work or union	66	80	63	36	50	62
Health insurance through some other group	26	23	27	36	21	24
Health insurance bought directly by yourself or your family	36	29	43	49	39	36
Medicare, that pays health care bills for people aged 65 and over and for some disabled people	20	6	8	74	12	12
Medicaid or public aid	7	3	6	13	23	5
Any other health insurance	2	1	2	3	3	3
None	5	5	9	2	11	5

Table B-3

FAMILY USE OF HEALTH CARE IN THE PAST TWELVE MONTHS

Q. How many visits, *excluding* overnight hospital stays, did you and all members of your family living with you make to a doctor's office, outpatient clinic, hospital emergency room, or any other place for medical care during the past twelve months — that is, since (DATE ONE YEAR AGO) 1982?

Q. Have you or has anyone in your family living with you been a patient overnight in a hospital during the past twelve months, since (DATE ONE YEAR AGO) 1982?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Number of visits to health care facilities (excluding overnight hospital stays)								
None	9	9	7	6	9	13	9	26
1 to 5	32	34	25	32	31	29	32	33
6 to 15	37	37	36	38	36	30	38	27
16 to 25	10	10	15	11	12	11	10	10
26 or more	11	10	15	11	11	16	10	3
Anyone in the family has been a patient overnight in a hospital								
Yes, has been a patient	33	30	48	34	36	33	36	20
No, has not been a patient	67	70	52	66	64	67	64	80